CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/09/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	
		15E680	B. WIN	G		07/22/2	011
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				I	ERS OF PROVIDENCE		
PROVIDE	ENCE HEALTH CAF	RE		SAINT	MARY OF THE WO, IN47876		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
K0000							
	A Life Safety Co	ode Recertification	K0000		Submission for this plan of		
		sure Survey was			correction shall not constitute		
		he Indiana State			admission by Providence He	alth	
					Care, Inc. to the allegations	.rt	
	Department of				contained in this survey report Providence Health Care Inc.	η ι .	
	accordance with	h 42 CFR 483.70(a).			specifically and generally de		
	Survey Date: 0	7/22/11			that the survey allegations an indicative of the quality of nu care and service provided to		
	Facility Number	. 003624			residents of this health care		
	Provider Number				facility. This plan of		
	AIM Number: 2				correction is submitted in	4 -	
	Ally Number. 2	200429840			accordance with the requrement of State and Federal law. W		
	Cumanana Daida	at Drawn Life			respectfully request paper	•	
	Surveyor: Bridge				compliance for this plan of		
	Safety Code Spe	ecialist			correction.		
	At this Life Safe	ety Code survey,					
	Providence Hea	lth Care was found					
	not in complian	ice with					
	Requirements f	or Participation in					
	Medicaid, 42 CI	FR Subpart					
		Safety from Fire					
	and the 2000 e	•					
	National Fire Pr						
		PA) 101, Life Safety					
		410 IAC 16.2. The					
	original North/						
	surveyed with	•					
	Existing Health	Care Occupancies.					
	This facility is lo	ocated in two, one					
	story buildings,	, the North/South					
LABORATOR'	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		ITITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

88B621

Facility ID:

003624

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E680		(X2) MUI A. BUILE		NSTRUCTION 01	(X3) DATE S COMPL 07/22/2	ETED	
		15E680	B. WING			0772272	011
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
PROVIDE	ENCE HEALTH CAP	RE			RS OF PROVIDENCE IARY OF THE WO, IN47876		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	P:	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	•	est, connected by a					
	=	dor. The buildings					
		ed to be of Type V					
	(111) construct	•					
	sprinklered. Th	ne facility has a fire					
	alarm system w	vith smoke					
	detection in the	e corridors, spaces					
	open to the cor	ridors, and					
	resident sleepir	ng rooms. The					
	facility has the	capacity for 70					
	residents and h	ad a census of 41					
	at the time of t	his survey.					
	Quality Review by I	Robert Booher, Life Safety					
		dical Surveyor on 07/27/11.					
	The facility was	found not in					
	compliance wit						
	aforementioned						
		s evidenced by:					
	requirements a	s evidenced by.					
K0046 SS=C		g of at least 1½ hour d in accordance with 7.9.					
	Based on recor	d review and	K00)46	We have revised our inspecti	on	08/12/2011
	interview, the f	acility failed to			form to include the fact that the	-	
	provide docum	•			30 second testing needs to b completed every month and	е	
	•	c testing at 30 day			annually tested for 90 minute	s.	
	-	nnual testing for 1			We have placed a tickler on t		
	1/2 hours for 2				electronic calendar of the		
	powered emerg	· ·			computer of the Director of Environmental Services so the	nat	
	fixtures. LSC 7.9.3 requires a			he will check and sign off on			
	functional test shall be conducted				fact that these tests have ind	eed	
		ed battery powered			been performed according to		

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Facility ID:

003624

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	t:	A. BUILI	DING	01		COMPL	
		15E680		B. WING	i			07/22/2	011
NAME OF P	ROVIDER OR SUPPLIER				STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
						RS OF PROVID			
PROVIDE	ENCE HEALTH CAF	RE			SAINT N	MARY OF THE W	VO, IN47876		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCE	ES		ID	PROVIDER'S PL	AN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY		P	PREFIX	CROSS-REFERENCEI	E ACTION SHOULD BE D TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORM	IATION)		TAG		CIENCY)		DATE
		ting system at 30				2:30 p.m. to 4	ust 2, 2011 from	1	
	=	r not less than 30					er tested the fi	rst	
	seconds and an	annual test shall				light for 90 min			
	be conducted for	or not less than 1				-	1 from 10:30 a.		
	1/2 hours. Wri	tten records of					econd light was	5	
	visual inspectio	ns and tests shall				tested for 90 r	code. (See atta	ched	
	be kept. This d	leficient practice				documents).A		5.100	
	could affect 23	residents on the				scheduled for			
	north/south wi	ng.							
	Findings includ	e:							
	J								
	Based on review	v of facility fire							
		on and test records	<u>.</u>						
		nmental services							
	supervisor and								
	· · · · · · · · · · · · · · · · · · ·	on 07/22/11 at 2:1	5						
		rator test records	,						
	· ·	s for documenting							
	•	ithly as well as 1							
		•	_						
	•	al tests for the tw	U						
	battery powered	- .							
	lighting fixture								
	-	ere the emergency	/						
	generator for th	·							
	•	ed. No entry for							
	testing the ligh	ting was entered							
	since August 20	010. At the time o	of						
	record review, t	the interim							
	administrator called the								
	maintenance office and reported there was no other documentation								
	of testing these								
FORM CMS-2	567(02-99) Previous Versio		vent ID: 88	I B621	Facility II	D: 003624	If continuation sl	neet Da	ge 3 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 15F680 07/22/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1 SISTERS OF PROVIDENCE PROVIDENCE HEALTH CARE SAINT MARY OF THE WO, IN47876 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 3.1 - 19(b)Fire drills are held at unexpected times under K0050 varying conditions, at least quarterly on each SS=F shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 We have enabled a monthly K0050 08/02/2011 Based on record review and computer activiated alert system interview, the facility failed to on the computer of the Manager ensure fire drills were conducted of environmental services and the on every shift during 2 of the past computer of the office of the Assistant to the Administrator of 4 quarters. This deficient practice Providence Health Care. This affects all occupants on the alert will activate each month on north/south wing. the 5th day of the month at which time the administrator and the manager of environmental Findings include: services will check the fire drill longs and enusre they are in Based on a review of monthly Fire compliance for the required testings for all three shifts for their Drill Reports for the past year with quarterly fire drills. In the event the environmental services that neither of the aforeto director and interim administrator mentioned persons would be on 7/22/11 at 1:30 p.m., fire drill available on the 5th day of any given month, prior arrangements documentation was not found for will be made to forward the alert the first shift during the fourth to an appropriate mangement guarter of 2010 or for the first, staff person directly involved with Providence Healt Care and second and third shifts during the knowledgable of our proceedures first quarter of 2011. The interim for performing a fire drill. When all administrator said at the time of

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	. BUILDING	01	COMPLETED
∥ 15F680 	WING		07/22/2011
		DDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER	1 SISTE	RS OF PROVIDENCE	
PROVIDENCE HEALTH CARE		MARY OF THE WO, IN47876	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
· · · · · · · · · · · · · · · · · · ·	1710	fire drills have been fully	DATE
record review, there had been		executed on all three shifts the	ne
significant personnel changes and		Manager of Environmental	
the drills had not been conducted.		services will record said drills	in
		the log book and notify the Administrator.	
3.1-19(b)		Administrator.	
3.1-51(c)			
K0051 A fire alarm system with approved			
SS=F components, devices or equipment is installed according to NFPA 72, National Fire Alarm			
Code, to provide effective warning of fire in			
any part of the building. Activation of the			
complete fire alarm system is by manual fire			
alarm initiation, automatic detection or			
extinguishing system operation. Pull stations in patient sleeping areas may be omitted			
provided that manual pull stations are within			
200 feet of nurse's stations. Pull stations are			
located in the path of egress. Electronic or			
written records of tests are available. A			
reliable second source of power is provided. Fire alarm systems are maintained in			
accordance with NFPA 72 and records of			
maintenance are kept readily available. There			
is remote annunciation of the fire alarm			
system to an approved central station.			
19.3.4, 9.6 Based on observation and	K0051	We have contacted our fire a	larm 08/12/2011
	130031	contractor, Simplex-Grinell,	00/12/2011
interview, the facility failed to		Indianapolis, IN. to come inst	I
ensure 1 of 3 fire alarm panels in		an automatic smoke detectio	
an area not continuously occupied		device in the entry vestibule of north/south wing of Providen	I
was provided with automatic		Health Care to ensure notific	
smoke detection to ensure		of a fire before the fire alarm	
notification of a fire at the location		panel which is not continuous	- 1
before it could be incapacitated by		occupied and/or monitored co	ould

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E680		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 01	(X3) DATE S COMPLI 07/22/20	ETED	
	PROVIDER OR SUPPLIER		1 SISTE	ADDRESS, CITY, STATE, ZIP CODE ERS OF PROVIDENCE MARY OF THE WO, IN47876	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	automatic smo provided at the fire alarm control located in an accupied to provide a fire in that located in that located in an accupied to provide in that located in that located in that located in that located in the located in t	e location of each rol unit which is not rea continuously ovide notification of cation. This ce affects all le: Evation with the services director on 35 p.m., an arm control panel ated in the entry e north/south wing continuously was not electrically a smoke detector. Intal services lat the time of e panel was not		be incapacitated by fire. The scheduled to do the work on Tuesday, August 9, 2011. Jir Brown, Director of Facilities Maintenance, will monitor th instilation and report to the Administrator when the work completed.	n e	
K0144 SS=F	exercised under lomonth in accordar 3.4.4.1.	spected weekly and bad for 30 minutes per loce with NFPA 99.	K0144	While we have been running	ı load	08/19/2011
	basea on miler	new and record				55. 15, 2011

	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E680	Ĺ	LDING	01	(X3) DATE S COMPL 07/22/2	ETED
	ROVIDER OR SUPPLIER		•	1 SISTE	DDRESS, CITY, STATE, ZIP CODE RS OF PROVIDENCE MARY OF THE WO, IN47876		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	emergency ger power to the e systems for the LSC 7.9.2.3 and Care Facilities, requires month generator set s accordance wit Standard for Er Standby Power 110, 6–4.2 req in Level 1 and 2 service s under operatin less than 30 per (Emergency Po- nameplate ratin for a minimum NFPA 99, 3–5.4 written record performance, e and repairs sha maintained and inspection by to jurisdiction. T	mplete for testing 1 of 1 herators providing mergency lighting north/south wing. d NFPA 99, Health 3-4.4.1.1(a) hly testing of the hall be in h NFPA 110, the mergency and Systems. NFPA uires generator sets hall be exercised g conditions or not ercent of the EPS wer Supply) hg at least monthly, of 30 minutes. 4.2 requires a of inspection, exercising period all be regularly d available for he authority having his deficient s all occupants of h wing.			tests according to our understanding of the code, and while more than sufficier the load we pull in our small facility, they are not to the levesting according to NFPA 110 which states that the load must be run at 25 % of name for 30 minutes, then at 50% for 30 minutes, followed by 75% for minutes for a total of 2 how we have contacted Sycamor Engineering, of Terre Haute, the contractor who performs test for us, and have reqested that they conduct another load bank test according to NFPA 110. Facilities Maintenance Director, Jim Brown, will ove this testing proceedure and document that it was tested according to the code requirements. He will also at that the automated settings four monthly testing be set so generators can be exercised monthly for 30 minutes with available load to meet federa certification and state licensurequirements. The NFPA 110 for generator testing will be reviewed annually by the Face Maintenance Director, and the Health Care Administrator be the annual test is conducted assure compliance to the coreminder to do so will be place that the accomputer of the Facility Maintenance Diector, the Health Facility Administrator, the Executive Assistant to the Health Facility Administrator.	vel of d test eplate for 6 for urs. re IN., this d d A rsee ssure for the all ure code cilities ne effore to de.A ce on and e	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E680		LDING	NSTRUCTION 01	(X3) DATE S COMPL 07/22/20	ETED	
	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, STATE, ZIP CODE ERS OF PROVIDENCE MARY OF THE WO, IN47876	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	Generator Test records with the services director administrator of p.m., the generator han 30 percent load capacity dests. (The load 2011 was 13.7 addition the test of the run time compand "cool down (minutes)." As bottom of the regenerator for 3 a fifteen (15) meriod." At 2:507/22/11, the tested with mastarted within the Maintenance # documented ever generator for the records reflector readings. He awas done by ar because there we load available the each month at review of a load are review of a load are records.	e environmental or and interim on 07/22/11 at 2:10 rator load on the enerator was less t of the generator's uring the monthly d recorded for June percent.) In st was documented: eleted: 25 (minutes) completed: 10 rerisks at the records noted, "run 0 minutes and then einute cool down 0 p.m. on generator was intenance # 1 and two seconds. 1 said he rery test of the ene facility and ed the actual lso said a load test outside contractor was not enough o test the generator				

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Event ID:

88B621

Facility ID:

003624

If continuation sheet

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CON	ISTRUCTION 04	(X3) DATE S COMPL	
ANDILAN	or correction	15E680	A. BUILDING	G	01	07/22/2	
			B. WING	REET AL	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				RS OF PROVIDENCE		
	ENCE HEALTH CAP				IARY OF THE WO, IN47876		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	- 1	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREI TA		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
1110	the environmer	•	111				Ditte
		terim administrator					
		t 2:10 p.m. noted					
		•					
		h generator was ninutes under 34					
		The environmental					
	•	risor and interim					
		igreed at the time					
	of review, 34 p	-					
	enough for a fu						
	chough for a re	in road test.					
	3.1-19(b)						
K0000							
	A Life Safety Co	ode Recertification	K0000		Submission for this plan of		
		sure Survey was	1,0000		correction shall not constitute	-	
		he Indiana State			admission by Providence He Care, Inc. to the allegations	alth	
	Department of				contained in this survey repo	rt.	
		h 42 CFR 483.70(a).			Providence Health Care Inc.		
					specifically and generally der		
	Survey Date: 0	7/22/11			that the survey allegations ar indicative of the quality of nur care and service provided to		
	Facility Number	r· 003624			residents of this health care		
	Provider Numb				facility. This plan of		
	AIM Number: 2				correction is submitted in accordance with the requrem	ents	
					of State and Federal law. W		
	Surveyor: Bridg	get Brown, Life			respectfully request paper		
	Safety Code Sp				compliance for this plan of correction.		
	At this Life Safety Code survey,						
	Providence Hea	llth Care was found					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E680		A. BUILDIN		NSTRUCTION 02	(X3) DATE S COMPL 07/22/2	ETED	
	PROVIDER OR SUPPLIER		1 :	SISTE	DDRESS, CITY, STATE, ZIP CODE ERS OF PROVIDENCE MARY OF THE WO, IN47876		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	TIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Medicaid, 42 C 483.70(a), Life and the 2000 e National Fire Pr Association (NF Code (LSC) and East/West wing were surveyed New Health Car The East/West by a thirty foot north/south bu was determined (111) construct sprinklered. The alarm system we detection in the open to the corresident sleepin facility has the residents and hat the time of to the facility was compliance with aforementioned.	For Participation in FR Subpart Safety from Fire Edition of the Ed					

		(X2) MULTIPLE CONSTRUCTION (X3) DATE S O2 COMPLE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15E680	A. BUII	LDING	02	07/22/2	
		13E080	B. WIN			0112212	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ERS OF PROVIDENCE		
PROVID	ENCE HEALTH CAF	RE			MARY OF THE WO, IN47876		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A Life Safety Co	ode Recertification	K0	0000	Submission for this plan of correction shall not constitute	a an	
	and State Licen	sure Survey was			admission by Providence He		
	conducted by t	he Indiana State			Care, Inc. to the allegations		
	Department of	Health in			contained in this survey repo	rt.	
	accordance wit	h 42 CFR 483.70(a).			Providence Health Care Inc. specifically and generally de	nina	
	Survey Date: 0	7/22/11			that the survey allegations and indicative of the quality of nu care and service provided to	ons are of nursing led to	
	Facility Number	r: 003624			residents of this health care		
	Provider Numb				facility. This plan of correction is submitted in		
	AIM Number: 2	200429840			accordance with the requrem	nents	
					of State and Federal law. W		
	Surveyor: Bridg	get Brown. Life			respectfully request paper		
	Safety Code Sp				compliance for this plan of correction.		
					correction.		
	At this Life Safe	ety Code survey,					
	Providence Hea	llth Care was found					
	not in compliar	nce with					
	Requirements f	or Participation in					
	Medicaid, 42 C	-					
	· ·	Safety from Fire					
	and the 2000 e	·					
	National Fire Pr						
		FPA) 101, Life Safety					
	1	410 IAC 16.2. The					
	· ' '	and therapy suite					
	1	with Chapter 18,					
	· ·	e Occupancies.					
	Ficultii Cai	c occupancies.					
	The East/West	wing is connected					
	by a thirty foot	corridor to the					
	north/south bu	ilding. The facility					
	was determined	d to be of Type V					

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED
		15E680	B. WING		07/22/2011
NAME OF P	ROVIDER OR SUPPLIER		ı	ADDRESS, CITY, STATE, ZIP CODE ERS OF PROVIDENCE	
PROVIDE	ENCE HEALTH CAP	RE	I	MARY OF THE WO, IN47876	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE COMPLETION DATE
	(111) construct	ion and fully			
		ne facility has a fire			
	alarm system w	vith smoke			
	detection in the	e corridors, spaces			
	open to the cor	ridors, and			
	resident sleepir	ng rooms. The			
	facility has the	capacity for 70			
	residents and h	ad a census of 41			
	at the time of t	his survey.			
	The facility was	found not in			
	compliance wit	h the			
	aforementioned	d regulatory			
	requirements a	s evidenced by:			
K0029 SS=E	with 8.4. The area hour fire-rated bar fire-rated door, wit accordance with 8	are protected in accordance as are enclosed with a one rier, with a 3/4 hour hout windows (in .4). Doors are self-closing in accordance with			
	7.2.1.8. 18.3.2.1	1			
	Based on obser		K0029	After investigation we found we have limited space anywh	00,-2,-0
	interview, the f	•		else to store the soiled linen	loic
		azardous areas in		collection receptables and to	
		ving, such as soiled		in compliance we are going t install hydraulic self closing of	
	linen collection	•		hardware to the doors to the	
		gallons within a 64		where the soiled linens are k	•
		a, were located in ed with latching,		We have checked every place where we store soiled linens	
		ors. Sprinklered		clothing and have found then	
	•	is are required to		only two such doors which no	
		a a a reguired to		attention. All other said door	8

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li ´		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	02	COMPL	
		15E680	B. WIN	۱G		07/22/2	011
NAME OF I	PROVIDER OR SUPPLIER	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	ERS OF PROVIDENCE		
PROVID	ENCE HEALTH CA	RE		SAINT	MARY OF THE WO, IN47876		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	be equipped w	-			have the proper closing equipment on them.On 8/1 V	Vork	
	doors or with o	doors which close			orders were placed with the	VOIR	
	and latch auto	matically upon			Facilites Management Office		
	activation of th	ie fire alarm system.			the Sisters of Providence to		
	This deficient p	oractice a affects			address the self closing door		
	visitors, staff a	nd 18 residents on			hardware mechanisms of bo the East and West	uı	
	the east/west v	wing.			Shower/Bathing areas. Pucl	nase	
					orders have been obtained a	ind	
	Findings includ	de:			according to shipment shedu	ıling	
					of the parts the hydrolic self closing hardward will be insta	allod	
	Based on obse	rvation with the			on the doors no later than	alleu	
		services director on			8/19/11. These items have b	een	
		veen 11:20 a.m. and			placed on the priority list to b	е	
		o bathing rooms			completed by		
	•	ollection sites for			8/19/11.Environmental servion Director, Dave Kable, will be		
		soiled linen carts in			monitoring to make sure the		
					closing hardware for the doo		
		had the capacity of			installed and report back to t	he	
	_	35 gallon gallon			Administrator at that time.		
		ceptacle was also					
		bathing area. The					
		e than half full. The					
		self closer and were					
		with a deadbolt					
		d to be operated					
	1	gage and hold the					
	door tightly clo						
	environmental	services director					
	agreed at the t	ime of					
	observations, t	he doors did not					
	meet the requi	rements for the					
	materials store	ed in the rooms.					
	3.1-19(b)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E680		(X2) M A. BUII B. WIN	LDING G	NSTRUCTION 02	(X3) DATE: COMPL 07/22/2	ETED	
	PROVIDER OR SUPPLIER		•	1 SISTE	ADDRESS, CITY, STATE, ZIP CODE ERS OF PROVIDENCE MARY OF THE WO, IN47876		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0046 SS=C	duration is provided 18.2.9.1 Based on recordinterview, the for provide docum second periodic intervals and an 1/2 hours of 2 powered emerging fixtures. LSC 7 functional test on every require emergency light day intervals for seconds and arbe conducted for 1/2 hours. Write visual inspection be kept. This could affect 18 east/west wing. Findings included Based on review safety inspection with the environ supervisor and	acility failed to entation of 30 c testing at 30 day nual testing for 1 of 2 battery gency lighting 7.9.3 requires a shall be conducted ed battery powered ating system at 30 or not less than 30 or annual test shall for not less than 1 tten records of ons and tests shall deficient practice residents on the . de: w of facility fire on and test records nmental services	K	0046	We have revised our inspect form to include the fact that the 30 second testing needs to be completed every month and annually tested for 90 minute. We have placed a tickler on electronic calendar of the computer of the Director of Environmental Services so the will check and sign off on fact that these tests have incompleted according to code. On August 2, 2011 from 2:30 p.m. to 4:00 p.m. Randy Cesinger tested the filight for 90 minutes, and on August 3, 2011 from 10:30 at to 12:00 the second light was tested for 90 minutes, both according to code. (See attadocuments). An inservice is scheduled for August	he be	08/12/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15E680			(X2) MUI A. BUILD B. WING		o2	(X3) DATE S COMPLI 07/22/20	ETED
NAME OF P	ROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CODE		
PROVIDE	ENCE HEALTH CAF	RE			RS OF PROVIDENCE ARY OF THE WO, IN47876		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	included space 30 second more 1/2 hour annual battery powere lighting fixture power plant who generator for the was housed. Nother lighting was housed and the lighting was administrator of maintenance of	d emergency s located in the here the emergency he east/west wing o entry for testing s entered since At the time of the interim alled the ffice and reported ther documentation					
K0050 SS=F	varying conditions shift. The staff is f is aware that drills routine. Responsi conducting drills is competent person exercise leadershi conducted betwee announcement ma	s who are qualified to p. Where drills are n 9 PM and 6 AM a coded ay be used instead of 18.7.1.2 d review and	K00	050	We have enabled a monthly computer activiated alert syston the computer of the Mana		08/02/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	02	COMPI	LETED
		15E680	B. WIN			07/22/2	2011
			B. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			ERS OF PROVIDENCE		
PROVIDI	ENCE HEALTH CA	RE		1	MARY OF THE WO, IN47876		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	1	ID	<u></u>		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		lls were conducted			of enviromental services an	d the	
		during 2 of the past			computer of the office of the	;	
	=	· · ·			Assistant to the Administrate		
	·	nis deficient practice			Providence Health Care. Th	_	
	affects all occu				alert will activate each mont the 5th day of the month at		
	east/west wing	g.			time the administrator and t		
					manager of environmental		
	Findings inclu	de:			services will check the fire of	Irill	
					longs and enusre they are in	n	
	Based on a rev	riew of monthly Fire			compliance for the required		
		or the past year with			testings for all three shifts for		
	the environme				quarterly fire drills.In the even that neither of the aforeto	anı	
		iterim administrator			mentioned persons would b	е	
					available on the 5th day of a		
		1:30 p.m., fire drill			given month, prior arrangen		
		n was not found for			will be made to forward the		
		during the fourth			to an appropriate mangeme		
	quarter of 201	0 or the first,			staff person directly involved Providence Healt Care and	J WILLI	
	second and th	ird shifts during the			knowledgable of our procee	dures	
	first quarter of	f 2011. The interim			for performing a fire drill.Wh		
	administrator	said at the time of			fire drills have been fully		
	record review.	there had been			executed on all three shifts	the	
	,	sonnel changes and			Manager of Environmental		
	-	not been conducted.			services will record said dril	ls in	
	1116 011115 1140 1 	iot been conducted.			the log book and notify the Administrator.		
	2.1.10/5)				, withingtrator.		
	3.1-19(b)						
	3.1-51(c)						

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		NSTRUCTION 02	(X3) DATE COMPL	
		15E680	B. WIN			07/22/2	011
		<u> </u>	D. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	ERS OF PROVIDENCE		
PROVIDE	ENCE HEALTH CAF	RE		1	MARY OF THE WO, IN47876		
							ave:
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
		<u> </u>	 	IAG	BEIGERET		DATE
K0051 SS=F	A fire alarm syster components, device according to NFPA warning of fire in a Activation of the coby manual fire alardetection, or exting Pull stations are local Electronic or writter available. A reliable is provided. Fire a maintained in according National Fire Alarmaintenance are kis remote annuncial system to an approximate approximate and consumption of a fire alarmatic smooth provided at the fire alarm contributed in an analysis of the provided at the fire alarm contributed in an analysis of the provided at the fire alarm contributed in an analysis of the provided in an analysis of the provided at the fire alarm contributed in an analysis of the provided in analysis of the provided in an analysis of the provided in analysis of the provided in an analysis of the provided in analysis of the provided in analysis of the provided in an analysis of the pro	ces or equipment is installed A 72, to provide effective any part of the building. Complete fire alarm system is rm initiation, automatic guishing system operation. Cocated in the path of egress. En records of tests are cole second source of power alarm systems are cordance with NFPA 72, and Code, and records of kept readily available. There attended to the fire alarm coved central station. Evation and facility failed to dire alarm panels in antinuously occupied with automatic contoning at the location decine at the location be incapacitated by 1–5.6 requires an ke detector be a location of each rol unit which is not rea continuously ovide notification of cation. This ce affects all	KO	0051	We have contacted our fire a contractor, Simplex-Grinell, Indianapolis, IN. to come instan automatic smoke detection device in the entry vestibule north/south wing of Providen Health Care to ensure notific of a fire before the fire alarm panel which is not continuous occupied and/or monitored obe incapacitated by fire. The scheduled to do the work on Tuesday, August 9, 2011. Jim Brown, Director of Facilities Maintenance, will monitor the instilation and report to the Administrator when the work completed.	tall n of the ce ation sly ould y are	08/12/2011
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CENTERSTON	WEDICHKE & MEDIC	- AID SERVICES					IB 110: 0750-0571
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	02	COMPI	LETED
		15E680				07/22/2	2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹					
DD 6) (ID)	NOT UEALTH OA	DE			ERS OF PROVIDENCE		
PROVIDENCE HEALTH CARE			SAINT	MARY OF THE WO, IN47876			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	AIL .	DATE
i			İ				i
	Rased on obse	rvation with the					
		services director on					
	07/22/11 at 2	:35 p.m., an					
	ancillary fire al	arm control panel					
	(FACP) was loc	ated in the entry					
		e north/south wing					
	which was not	•					
	occupied and v	was not electrically					
	supervised by	a smoke detector.					
	The fire panel	served a fire system					
	•	•					
		•					
	agreed at the t	ime of observation,					
	the panel was	not continuously					
	visible to staff.						
	2.1.10/b)						
	5.1-19(D)						
	supervised by The fire panel protecting the environmental agreed at the t	served a fire system entire facility. The services director ime of observation, not continuously					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E680			(X2) MULT A. BUILDI B. WING		STRUCTION 02	(X3) DATE S COMPL 07/22/20	ETED
	PROVIDER OR SUPPLIER		/	1 SISTEF	DRESS, CITY, STATE, ZIP CODE RS OF PROVIDENCE ARY OF THE WO, IN47876		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
K0074 SS=E	and other loosely serving as furnishicare occupancies provisions of 10.3 for the Installation Shower curtains a 701. Newly introduced health care occup specified when tes methods cited in 18.7.5.1, 1, NFPA Newly introduced specified when tes method cited in 10 Based on obserinterview, the fensure sheer discurtains or valate ast/west residence in terview, the fensure sheer discurtains or valate ast/west residence in the fensure sheer discurtains or valate ast/west residence in the fensure sheer discurtains or valate ast/west residence in the fensure sheer discurtains or valate ast/west residence in the fensure sheer discurtains or valate ast/west residence in the fensure sheer discurtains or valate ast fensure sheet discurtains or valate ast fensure sheer discurtains or valate sheet discurtains or	mattresses meet the criteria sted in accordance with the 0.3.2 (3), 10.3.4, 18.7.5.3 evation and acility failed to eccorative hanging ances in 33 of 33 lent and activity indered flame 10.3.1 requires ains, and other hanging didecorations to stance as by testing in h NFPA 701, ods of Fire Tests for tion of Textiles and ficient practice	K00°	74	As of August 5, 2011 we have been unable to locate the documentation to prove that material of the sheer decorat hanging curtains or valances rendered flame resistant. The administrator has made numerous calls to those involumentation of the East/unit but has been unable to fisaid documentation. Ace Blin Drapes, 1621 S. 25th Street, Terre Haute, IN. was contact for said documentation but P. Bryan, the person who install the sheer decorative hanging curtains or valances is on vacation as of the writing of the POC. Therefore the Administrator has ordered the Environmental Services Direct to remove all sheer decorative hanging curtains and valances from resident rooms.	the ive is e ved West and & ed olly ed ed et ctor e	08/08/2011

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E680	(X2) MULTIPLE CC A. BUILDING B. WING	02	(X3) DATE SURVEY COMPLETED 07/22/2011
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE ERS OF PROVIDENCE MARY OF THE WO, IN47876	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Based on obserenvironmental 07/22/11 betw 3:20 p.m., wind activity rooms room had decovalances and/o The materials a indicating flam demonstrated accordance with environmental said at the time there was no experience of the cordance with the cord	rvations with the services director on veen 11:20 a.m. and dows in the two and every resident rative sheer or sheer curtains. All lacked evidence e resistance as by testing in h NFPA 701. The services director e of observation, vidence the treated to render		The sheer decorative hangi curtains or valances will be washed, and treated with retardant treatment according code before being rehung. Environmental Servic Director, Dave Kable will supervise the removal of curand valances and contact the Administrator when they has been fully removed.	n fire ng to res rtains

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E680		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 02	(X3) DATE: COMPL 07/22/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE ERS OF PROVIDENCE MARY OF THE WO, IN47876		
(X4) ID PREFIX TAG K0076 SS=E	(EACH DEFICIENC REGULATORY OR Medical gas storaç	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ge and administration areas ccordance with NFPA 99, Ith Care Facilities.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	3,000 cu.ft. are en separation. (b) Locations for s		K	0076	A sign was made and placed		08/12/2011
	interview, the face ensure 3 of 3 connonflammable of a consider oxygen were properly chained proper cylinder deficient practices of the well as visitors observed in the consurer of the container restrance of the container of the container restrance of the containe	acility failed to ylinders of gases such as roperly chained or proper cylinder the east/west e room. NFPA 99, cilities, equires cylinder or aint shall meet 6.2.1(b)27 which anding cylinders be ed or supported in a r stand or cart. This ce could affect e east/west wing as and 6 staff service area east/west wing.			the door of the storage room where the oxygen was improstored instructing staff not to store any oxygen in that part storage room at all. All oxyg has been removed from that room and is now stored on North/South wing of our build in a room where we store all oxygen, which is equipped wholders to properly support a securely store the canisters of prevent them from falling over inservice is currently underwall shifts of nursing personne the proper care and storage oxygen tanks. Jessica Bland under the direction of Robin Royce, Director of Nursing, is monitoring the inservice which Robin Royce wrote for the st	operly icular en ding with and to er.An ay for el on of d, s	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E680	(X2) MU A. BUIL B. WINC	DING	02	(X3) DATE S COMPL 07/22/20	ETED
	ROVIDER OR SUPPLIER			1 SISTE	DDRESS, CITY, STATE, ZIP CODE IRS OF PROVIDENCE MARY OF THE WO, IN47876		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
K0144 SS=F	or/22/11 at 11 oxygen cylinder counter top in the utility room with environmental said at the time cylinders should in the racks produced oxygen storage oxygen oxygen storage oxygen oxygen oxygen storage oxygen o	the east/west clean hout support. The services director of observation the dhave been stored ovided in the eroom. Expected weekly and ad for 30 minutes perce with NFPA 99. Tiew and record lity failed to mplete for testing 1 of 1 erators providing mergency lighting east/west wing. If NFPA 99, Health 3-4.4.1.1(a) ly testing of the hall be in the NFPA 110, the	K0	144	While we have been running tests according to our understanding of the code, and while more than sufficienthe load we pull in our small facility, they are not to the levesting according to NFPA 110 which states that the load must be run at 25 % of name for 30 minutes, then at 50% for 30 minutes for a total of 2 how we have contacted Sycamor Engineering, of Terre Haute, the contractor who performs test for us, and have requested that they conduct another load bank test according to NFPA	ot for yel of d test eplate for for urs. e IN., this d	08/19/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	02	COMP	
		15E680	B. WIN	IG		07/22/2	2011
NAME OF	PROVIDER OR SUPPLIEI	R		1	ADDRESS, CITY, STATE, ZIP CODE		
				1	ERS OF PROVIDENCE		
PROVID	ENCE HEALTH CA	RE .		SAINTI	MARY OF THE WO, IN47876		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	110. Facilities Maintenance		DATE
		luires generator sets			Director, Jim Brown, will ove	ersee	
	in Level 1				this testing proceedure and	,,,,,,	
	and 2 service s	shall be exercised			document that it was tested		
	under operatin	ig conditions or not			according to the code		
	less than 30 pe	ercent of the EPS			requirements. He will also a that the automated settings		
	(Emergency Po	wer Supply)			our monthly testing be set s		
	nameplate rati	ng at least monthly,			generators can be exercised		
	for a minimum	of 30 minutes.			monthly for 30 minutes with		
	NFPA 99, 3-5.	4.2 requires a			available load to meet feder certification and state licens		
	written record	of inspection,			requirements.The NFPA 110		
	performance, e	exercising period			for generator testing will be	7 0000	
	and repairs sh	all be regularly			reviewed annually by the Fa		
	maintained an	d available for			Maintenance Director, and t		
	inspection by t	the authority having			Health Care Administrator b the annual test is conducted		
	jurisdiction. T	· · · · · · · · · · · · · · · · · · ·			assure compliance to the co		
	1 *	s all occupants of			reminder to do so will be pla		
	the east/west	·			the computer of the Facility		
	line east, west	9.			Maintenance Diector, the Health Facility Administrator	and	
	 Findings include	de.			the Executive Assistant to the		
	Timamys merae				Health Facililty Administrato		
	Based on revie	w of the Monthly					
		ting/Inspection					
		ne environmental					
	services direct						
		on 07/22/11 at 2:20					
	1 '	rator load on the					
	_	erator was less than					
	· -	the generator's load					
	1	g the monthly tests.					
		rded for June 2011					
	1 ') In addition the					
		nented: "run time					
	completed: 20	(minutes) and "cool					

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	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E680		LDING	NSTRUCTION 02	(X3) DATE: COMPL 07/22/2	ETED
	PROVIDER OR SUPPLIEF		•	1 SISTE	DDRESS, CITY, STATE, ZIP CODE ERS OF PROVIDENCE MARY OF THE WO, IN47876		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	Asterisks at the records noted, 30 minutes and minute cool do 3:10 p.m. on 0 generator was maintenance # within two seco # 1 said he doo of the generator and records rereadings. He awas done by an because there load available teach month at review of a load contractor date the environmend director and in on 07/22/11 at the east/west of tested for 35 mpercent load.	tested with 1 and started 2 onds. Maintenance 2 cumented every test 2 or for the facility Slected the actual Also said a load test An outside contractor A was not enough A test the generator A dest done by the A do 15/24/11 with A data services A terim administrator A test 2:10 p.m. noted A generator was A inutes under 36 A The environmental A visor and interim A agreed at the time A error was not					

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			_					
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	02	COMPI	LETED	
		15E680	B. WIN			07/22/2	011	
			D. 11111					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, C					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				1 SISTERS OF PROVIDENCE				
DDU//ID	ENCE HEALTH CA	PE			MARY OF THE WO, IN47876			
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(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	PECHI ATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	DATE	
IAU	REGULATORT OR	LSC IDENTIFTING INFORMATION)		IAU			DATE	
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

88B621

Facility ID: 003624

If continuation sheet

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